BRET SOKOLOFF, MD

Today's date: ___________ E-mail: ____

First Name:_____________________________Middle:________________Last:____________________________________

Home Address:____City:_______________________State:____Zip:_________

Social Security Number:_______________________________ Date of Birth:_____________ Male ❑ Female ❑

Home Phone:_________________________ Cell Phone: ________________________Work Phone:___________________

Primary Care Physician:____________________________________ Referring Physician:______________________________

Emergency Contact:______________________________________ Phone:__________________________________

Responsible Party:____ Relationship to Patient:_____________________________

Insurance: We will file your insurance; however, you will receive monthly statements. At each visit you will be responsible for paying co-pays, deductibles and balance due after insurance. You are responsible for promptly responding to all insurance inquiries.

Primary	Secondary
Insurance Company(1)_____________________________	Insurance Company(2):_________________________
Phone#:____	Phone#:_____________________________________
Policy#:____	Policy#:_____________________________________
Group/Plan#:____________________________________	Group/Plan#:_________________________________
Policy Holder:___________________________________	Policy Holder:________________________________
Policy Holder's: Date of Birth__________ Male ❑ Female ❑	Policy Holder's: Date of Birth_________ Male ❑ Female ❑
Policy Holder's SSN:_____________________________	Policy Holder's SSN:______________________________

In consideration of the medical services rendered and/or to be rendered, I/we agree to pay OrthoNow, PLLC and/or its physician(s) the regular charge for said services. I/We further agree to pay any court costs and reasonable attorney's fees in the event that this account has to be referred to an attorney for collection. I/We understand that I/We are responsible for all charges not paid by insurance. I/We certify that I/We have read the above or had it explained to me/us and agree to all of its terms and as evidence of this face sign my/our name below.

Patient Signature:____

Responsible Party Signature:____